MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-D

CERTIFICATE OF DEATH

02544

Reg. Diat. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil Co.

City or town near Elkton Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elkton RD 5

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence W Abernathy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Albert J. Abernathy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug-20-1874

8. AGE:	Years	Months	Days	If less than one day
	71	6	12	..... hrs. ..... min.

9. Birthplace Harford County-Md (Town, county, and state)

10. Usual occupation Funeral Director

11. Industry or business

FATHER 12. Name William H Whitten

13. Birthplace Ireland

MOTHER 14. Maiden name Elizabeth Taylor

15. Birthplace Harford County Md

16. Informant Anna A Janney

Address Elkton, R.D. 3 Md

17. Burial (Burial, cremation, removal. Which?) Date thereof Mar 8 1946 (month) (day) (year)

Cemetery or crematory Cherry Hill

Location near Elkton Md.

18. Funeral director J. E. Tyson

Address Rising Sun Md.

19. Mar 5 19 46 F H Frazer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 10 40 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2 1944 to March 4 1946 and that I last saw h... alive on March 5 1946

Immediate cause of death	DURATION
Carcinoma of Lung	about
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dilford R. Greenley M.D. M. D. or other

Address Elkton, Md Date signed March 5

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02545

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 days

Hospital, Institution, or street address where death occurred:

U.S.Naval Hospital, Bainbridge, Md.

How long in hospital or institution? 5 January 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Delaware

City or town: West Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No. Evergreen Street, Route #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

ABERNETHY, Paul Edward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1927

8. AGE: Years	Months	Days	If less than one day
18	5	10	..... hrs. ..... min.

9. Birthplace: Chester Delaware Penna.

(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business

FATHER — 12. Name: Julian Abernethy

FATHER — 13. Birthplace

MOTHER — 14. Maiden name

MOTHER — 15. Birthplace

16. Informant: Records Office

Address: U. Naval Hospital, Bainbridge, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 5 1946 (month) (day) (year)

Cemetery or crematory

Location: R.D., West Grove, Pa.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Mar 5 1946 (Date rec'd by registrar) Jno E. Dwight Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 March 1946, at 12:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 January 1946 to 3 March 1946

and that I last saw h.im alive on 3 March 1946

	DURATION
Immediate cause of death: Acute Nephritis	62 days
Due to: Streptococcal Infection (Acute Tonsillitis)	5 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Confirmed above diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry C. Oard, Capt. (MC) USNR (M.D.)

M. D. or other

Address: U.S.Naval Hospital, Bainbridge Date Signed: 3 Mar. 1946

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (802)

CERTIFICATE OF DEATH

02546

Reg. Dist. No. 90

1. PLACE OF DEATH:
County: Cecil
City or town: Rural Back Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rural Back Point Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry W. Bailey jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 13 1938

8. AGE: Years: 8 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Elkton Cecil Md.
(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER — 12. Name: Henry W Bailey Sr.
13. Birthplace: Caldwell Wed.

MOTHER — 14. Maiden name: Vitta M. Forrest
15. Birthplace: Wilmington Del.

16. Informant: Henry W Bailey Sr.
Address: R.D. Back Point md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 16/46 (month) (day) (year)
Cemetery or crematory: Cecilton
Location: Cecilton

18. Funeral director: Edward Fellows
Address: Millington Md.

19. Mar 15th 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13. 1946 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-24 1946 to March 13 1946
and that I last saw h him alive on March 13. 1946

Immediate cause of death: Abscess of Brain — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm E. Van Durden M.D. M. D. or other
Address: Chesapeake City Md. Date signed: 3-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

02547 Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours
Hospital, institution, or street address where death occurred: Union Hospital Elkton
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Warwick
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Gloria Boyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 14 1946

8. AGE: Years | Months: 2 | Days: 8 | If less than one day: hrs. min.

8. Birthplace: Warwick, Md. Cecil
(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER
12. Name: Walter Boyer
13. Birthplace

MOTHER
14. Maiden name: Catherine Boyer
15. Birthplace

16. Informant: Catherine Boyer
Address: Warwick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/26/46 (month) (day) (year)

Cemetery or crematory: Sassafras, Md.

Location

18. Funeral director: Austin O. Faulk.
Address: 827 Pine St. Wilm. Del.

19. Mar 25 1946 (Date rec'd by registrar) F. H. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1946 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Lobar Pneumonia	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other
Address: Rising Sun Md. Date signed 3/22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (314)

CERTIFICATE OF DEATH

02548

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Cecil

City or town Earleville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Earleville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James A. Brown

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1863

8. AGE: Years	Months	Days	If less than one day
82			hrs. min.

9. Birthplace Queen Annes Md. (Town, county, and state)

10. Usual occupation Retired Blacksmith

11. Industry or business

FATHER 12. Name James A Brown Sr.

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Mary V Woolyhan

MOTHER 15. Birthplace Md.

16. Informant Mrs James A Brown

Address Earleville Md.

17. Burial Date thereof 3/18/46 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ Johnstown

Location near Earleville Md.

18. Funeral director Edward Fellows

Address Millington Md.

19 Mar 7th 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1943, to March 4 1946

and that I last saw h. alive on March 1, 1946

Immediate cause of death	DURATION
Glycosuria Nephritis	5 Years
Uremia Terminal	3 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter L. Lewis M. D. or other

Address Middletown, Del. Date signed 3/7/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02549

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: ELKTON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Union Hosp., Elkton
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Principio Furnace
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Janet L. Cameron

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: William Cameron
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1860.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
85	11	27		

9. Birthplace: Edinburgh Scotland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: James Lochie
13. Birthplace: UNKNOWN

MOTHER
14. Maiden name: Jane Stewart
15. Birthplace: UNKNOWN

16. Informant: Hosp. Records, Union Hosp.
Address: Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 3 1946 (mooth) (day) (year)
Cemetery or crematory: Principio Furnace
Location: Principio Furnace, Md.

18. Funeral director: Lee C. Patterson & Son
Address: Oxmoor, Md.

19. Mar 31 1946 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1946, at 4 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1946, to March 30 1946
and that I last saw her alive on March 29 1946

Immediate cause of death	DURATION
Chronic endocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. T. Morrison, M.D. M. D. or other
Address: Elkton Md Date signed: 3-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162)

CERTIFICATE OF DEATH

02550

Reg. Dist. No. 9/1

1. PLACE OF DEATH

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: Chesapeake City, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Chesapeake City, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Josephine McKenna Connolly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Widowed

6.(b) Name of husband or wife: James E. Connolly

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1872

8. AGE: Years	Months	Days	If less than one day
74		10	..... hrs. ..... min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER — 12. Name: Thomas McKenna

FATHER — 13. Birthplace: Baltimore, Md

MOTHER — 14. Maiden name: Mary E. Kerwin

MOTHER — 15. Birthplace: Baltimore Md

16. Informant: Mrs. Fredrick Speed

Address: Chesapeake City, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 16 1946 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md

18. Funeral director: H. W. Peppin

Address: Elkton, Md

19. March 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1943 19..... to March 14 1946

and that I last saw h... alive on March 13 1946

Immediate cause of death	DURATION
Senile dementia	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. W. Davis MD

M. D. or other

Address: Chesapeake City Md Date signed: 3/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

02551 94

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Joseph Connor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 23 1946

8. AGE: Years | Months: 1 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: North East Md. (Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER — 12. Name: Samuel M. Connor

13. Birthplace: North East Md.

MOTHER — 14. Maiden name: Dotty Mae Pusteau

15. Birthplace: Elkton Md.

16. Informant: Samuel M. Connor

Address: North East Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 14 1946 (month) (day) (year)

Cemetery or crematory: Union

Location: Elkton Rural

18. Funeral director: Joseph R. Frame

Address: North East Md

19. 3-14 1946 Lida V. Evans

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1946 at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Non Closure of Foramen of Botal	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Woodcock M.D. Medical Examiner Cecil County

M. D. or other

Address: Rising Sun Md. Date signed: 3-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02552

Reg. Dist. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
County: Cecil Co. Md.
City or town: Colora Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil Co.
City or town: Colora Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Martha A. Davis

3.(b) Social Security Number:

4. Sex: Femal
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Harvey T. Davis
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): Mar 13 1872
8. AGE: Years: 74 Months: Days: 8 If less than one day: hrs. min.
9. Birthplace: Colora Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Samuel B. Nesbitt
13. Birthplace: Colora Md.
MOTHER 14. Maiden name: Susan Ferguson
15. Birthplace: Colora Md.
16. Informant: Harvey T. Davis
Address: Colora Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 22 1946 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora Md.
18. Funeral director: J. E. Tyson
Address: Rising Sun Md.
19. Mch 21 46 (Date received by registrar) L. M. Washington Registrar
Permit Issued 3-21-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1946 at 4.30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1946 to March 19 1946 and that I last saw her alive on 3-14 1946

Immediate cause of death	DURATION
Cancer	
Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. L. Dorsey M.D. M. D. or other
Address: Rising Sun Md. Date signed: 3/21-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02553

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
Locust Lane, Elkton, Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Locust Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret B. Devlin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	(Widowed)

6.(b) Name of husband or wife: David T. Devlin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 24, 1867

8. AGE: Years	Months	Days	If less than one day
78	10	27	hrs. min.

9. Birthplace: Lewisville, Mayland (Town, county, and state)
10. Usual occupation: Seamstress
11. Industry or business
FATHER 12. Name: John Brown
FATHER 13. Birthplace: Lewisville, Md
MOTHER 14. Maiden name: Ellen Perry
MOTHER 15. Birthplace: Cecil Co, Md.
16. Informant: Ernest Brown
Address: Elkton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 24/46 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Cherry Hill Md
18. Funeral director: H.W. Pippin
Address: Elkton, Md
19. Mar 23 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1946, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1926, to March 21 1946
and that I last saw h-r alive on March 21 1946

Immediate cause of death	DURATION
acute Cardiac dilatation	
Due to: Chronic Myocarditis	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Herbert Bailey M.D.
M. D. or other
Address: Elkton Md Date signed: 3/22/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02554

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital Elkton, Md

How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: W Druick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sadie Foster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Cecil County (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER 12. Name: Robert Foster

13. Birthplace: no record

MOTHER 14. Maiden name: Margaret Clark

15. Birthplace: no record

16. Informant: Katie Brice

Address: Warwick Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-31-46 (month) (day) (year)

Cemetery or crematory: Bohemia manner cemetery

Location: near Church Town md.

18. Funeral director: F. Foster Davis

Address: Townsend Del.

19. Mar 29 1946 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28th 1946, at 1.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22d 1946 to Mar 28 1946

and that I last saw h[illegible] alive on Mar. 28th 1946

Immediate cause of death	DURATION
Hemorrhages from bowel - probably Malignancy	
Due to	
Due to Paralysis - cerebral arterio sclerosis Cerebral softening Cystitis	7 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. H. McKnight M. D. or other

Address: Elkton - Md Date signed 3/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Katie Brisco

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142)

CERTIFICATE OF DEATH

02555

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: CECIL

City or town: Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Days.

Hospital, Institution, or street address where death occurred: 336-A

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mass. County:

City or town: Dorchester Mass
(If outside city or town limits, write RURAL and give nearest town)

Street No. 57 Chicktawbet St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War No. 11 ✓

3.(a) FULL NAME: FRAZIER, William Francis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: xxx Roberta Marilyn FRAZIER

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-26-21

8. AGE: Years	Months	Days	If less than one day
24	7	6	hrs. min.

9. Birthplace: E. Braintree, Mass
(Town, county, and state)

10. Usual occupation: USMCR

11. Industry or business:

FATHER — 12. Name: —

13. Birthplace: —

MOTHER — 14. Maiden name: Hazel FRAZIER.

15. Birthplace: —

16. Informant: USMC Record

Address: P.S.C. N.T.C. Mar.Bks. Bainbridge, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 5, 1946 (month) (day) (year)

Cemetery or crematory:

Location: To, Dorchester, Mass.

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. March 4 19 46 Irma E. Daugherty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 March 1946 19 at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 February 19 46 to 2 March 19 46 and that I last saw him alive on 2-11-46 19

	DURATION
Immediate cause of death: Axphyixiation	Not Known
Due to: Strangulation	Indef.
Due to: Hanging	Indef.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None.

None Date of op. None

Autopsy results: Death due to Asphyxia.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

~~Accident~~, suicide, or homicide: Suicide Date of 3-2-46

Where did injury occur? NTC, Bainbridge, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Naval Training

Means of injury: Hanging Injured at work? No. Center

23. SIGNATURE: Wm G. Green M. D. or other

Address: Marine Bks. Center, Bainbridge Md. Date signed 3-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02556

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yrs.
Hospital, institution, or street address where death occurred:
201 E Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 E Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lydia H. Greenfield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Widowed

6.(b) Name of husband or wife: Aquilla Greenfield
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 13, 1853

8. AGE: Years	Months	Days	If less than one day
92	6	16	hrs. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: Daniel Harvey
13. Birthplace: Childs, Md

MOTHER
14. Maiden name: Katherine Arthur
15. Birthplace: Baltimore, Md

16. Informant: Mr. John Harvey
Address: Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 1, 1946 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton, Md
18. Funeral director: H.W. Lipkin
Address: Elkton, Md

19. April 1, 1946 (Date rec'd by registrar) H R Bragg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 1946, at 6 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1925, to March 29 1946
and that I last saw her alive on March 29 1946

Immediate cause of death	DURATION
Cardio-renal vascular disease	
Due to	
Due to	
Other conditions Sarcoma of tonsils with metastasis	9 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herbert Bates M. D.
M. D. or other
Address: Elkton Md Date signed: 3/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

02557

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CECIL

City or town NEAR ANDORA

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 YEARS

Hospital, Institution, or street address where death occurred: Elkton RD 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CECIL

City or town ANDORA

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME GUSTAVUS HENDERSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband~~ or wife LELA HENDERSON

~~FEB 24 1867~~ 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB. 24 1867.

8. AGE: Years	Months	Days	If less than one day
79		27	....hrs. ....min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation RET FARMER

11. Industry or business

FATHER

12. Name JOHN S HENDERSON

13. Birthplace MARYLAND

MOTHER

14. Maiden name JANE SCOTT

15. Birthplace MARYLAND

16. Informant LELLA HENDERSON

Address ELKTON R.F.D # 3

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MARCH 27-46 (month) (day) (year)

Cemetery or crematory HEAD OF CHRISTIANA

Location NEAR NEWARK DELAWARE

18. Funeral director H. W. Pepper

Address Elkton, Md

19. Mar 26 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION P.M

20. DATE OF DEATH March 23, 1946, at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1945 to March 23, 1946 and that I last saw him alive on March 23, 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	March 4
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Lloyd F. Loveless MD M. D. or other 46

Address Elkton, Md. Date signed Mch. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-E

02558

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: VETERANS ADMINISTRATION, PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yr. 10 mo. 25 da.
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington County: Pierce
City or town: Takoma
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1300 E. 66th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War ✓

3.(a) FULL NAME: ISRAEL, George T.

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): July 5, 1891

8. AGE:

Years	Months	Days	If less than one day
54	10	20	... hrs. ... min.

9. Birthplace: Ottumwa, Iowa (Town, county, and state)
10. Usual occupation: Nomad
11. Industry or business: –

FATHER
12. Name: Frank Israel
13. Birthplace: Illinois

MOTHER
14. Maiden name: Sarah E. Turner
15. Birthplace: Illinois

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 27, 1946 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Pennington & Son
Address: Havre de grace, Md.

19. Mar 27 1946 (Date rec'd by registrar) Registrar: Irma E. Dorsey

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1946 at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1933, to March 25 1946 and that I last saw him alive on March 25 1946

Immediate cause of death	DURATION
Myocardial Degeneration	Over 10 yrs.
Due to: Coronary Arteriosclerosis	Over 10 yrs.
Due to:	
Other conditions: Psychosis with syphilis of the Central Nervous System, Meningo-Encephalitic type (Due to, or as a consequence of)	Over 12 yrs.

Major findings of operations: –
Date of op.: –
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? (City or town) – (County) – (State) –
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

23. SIGNATURE: Samuel C. Kahlan M.D. M. D. or other
Address: Acting Clinical Director, Veterans Administration, Perry Point, Md. Date signed: 3-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02559

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-10M

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RD 4
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Anna Johnie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Howard A Johnie
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 29 1875

8. AGE: Years: 70 Months: 11 Days: 3 If less than one day: hrs. min.

9. Birthplace: Cecil County, Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Jacob Hileman
13. Birthplace: Penna

MOTHER
14. Maiden name: Nicols
15. Birthplace: unknown

16. Informant: Mrs Grover Henderson
Address: Newark Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 8 1946 (month) (day) (year)
Cemetery or crematory: Rosebank Cemetery
Location: Calvert, Md

18. Funeral director: Joseph R. Grant
Address: North East, Md

19. Mar 6 1946 (Date rec'd by registrar) F H Finger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1946 at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1945 to March 4 1946
and that I last saw h...ew alive on March 1 1946

Immediate cause of death	DURATION
Advanced cardio-vascular renal disease.	
Due to:	
Due to:	
Other conditions: Lues.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: Howard N. Keeley M. D. or other
Address: Elkton, Md Date signed: March 6, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7a-2)

CERTIFICATE OF DEATH

02560 94

★ Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Cecil

City or town: Charlestown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Charlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Hattie E. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Richard Jones

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Aug - 23 1878

8. AGE: Years	Months	Days	If less than one day
67	7	4	hrs. min.

9. Birthplace: Charlestown Cecil Co. Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business —

FATHER — 12. Name: Robert Singleton

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Harmon

15. Birthplace: Penn.

16. Informant

Address: Charlestown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-30-46 (month) (day) (year)

Cemetery or crematory: Cemetery Methodist

Location: Charlestown, Md

18. Funeral director: Joseph R. Grant

Address: North East Md.

19. 3/30 (Date rec'd by registrar) 19 46 Lida V. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 19 46 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1 19 43, to March 27 19 46 and that I last saw h... alive on March 26 19 46

Immediate cause of death	DURATION
Chronic Valvular Heart Disease	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other

Address: Perryville Md. Date signed: 3/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02561

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: VETERANS ADMINISTRATION, PERRY POINT, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo. 23 days
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: –
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 E. University Pkwy.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: KELLY, William R.

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Unknown – deceased
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): August 8, 1894

8. AGE: Years	Months	Days	If less than one day
51	7	5	– hrs. – min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Civil Engineer
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point,

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-13, 1946 Md. (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md.
18. Funeral director: Holt & Johnson Inc. Hill and Johnson, Inc.
Address: Salisbury, Md.

19. March 13 19 46 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18 1945, to March 13 1946 and that I last saw him alive on March 13 1946

Immediate cause of death	DURATION
Myocardial Degeneration	Over 3 yrs.
Due to: Coronary Arteriosclerosis	Over 3 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: –
Date of op. –
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of –
Where did injury occur? – (City or town) – (County) – (State)
Injured at home, farm, industry, public place (where?) –
Means of injury – Injured at work? –

23. SIGNATURE: A. E. Trollinger M.D.
A. E. TROLLINGER, M.D. Clinical Director (or other)
Address: Veterans Administration, Perry Point, Md. Date signed: 3-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

02562

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Month 14 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Beaver
City or town: Aliquippa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Ellen Krivonak

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1945

8. AGE:

Years	Months	Days	If less than one day
	2	12	..... hrs. ..... min.

9. Birthplace: Parris Island, S. Carolina
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Edward J. Krivonak
13. Birthplace: Aliquippa, Pa.

MOTHER
14. Maiden name: Diana M. Yandrich
15. Birthplace: Juneau, Pa.

16. Informant: Edward J. Krivonak
Address: 105 Woodland Way, Aliquippa, Pa.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 14, 1946 (month) (day) (year)

Cemetery or crematory
Location: To, Aliquippa, Beaver Co., Pa.

18. Funeral director: Lew A. Patterson & Son
Address: Perryville, Md.

19. March 14 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 13 1946, at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/7 1946, to 3/13 1946 and that I last saw h.. alive on 3/13 1946

Immediate cause of death	DURATION
Spina Bifida	Since Birth
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. M. Hammell M.D. M. D. or other
Address: U.S. Naval Training Center Bainbridge, Md. Date signed: 3-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md.

02563

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
U.S.N. Hosp. NTC, Bainbridge, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mass. County: Hampshire
City or town: Amherst
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.#2 - Wright St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: LAMSON, Clarence Clyde

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Mother Augusta Lamson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 22, 1928

8. AGE: Years	Months	Days	If less than one day
18	0	22	..... hrs. ..... min.

9. Birthplace: Amherst, Mass.
(Town, county, and state)
10. Usual occupation: U. S. Navy
11. Industry or business
FATHER 12. Name: Clarence Lamson
13. Birthplace: Mass.
MOTHER 14. Maiden name: Augusta Lovett
15. Birthplace: Mass.
16. Informant: Records Office Naval Hospital
Address: Bainbridge, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 15, 1946 (month) (day) (year)
Cemetery or crematory:
Location: Amherst, Hampshire Co., Mass.
18. Funeral director: Lee A. Patterson & Son
Address: Berryville, Va.
19. March 15, 1946 (Date rec'd by registrar) By Irma E. Dunfee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 March 1946, at 1:27 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 March 1946 to 14 March 1946 and that I last saw him alive on 13 March 1946

	DURATION
Immediate cause of death: Encephalitis Acute (post-vaccinial)	36 hrs.
Due to:	
Due to:	
Other conditions: German Measles	2 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Confirmed Clinical diagnosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Harry C. Oard
HARRY C. OARD, Capt. (MC) USNR
M. D. or other
Address: U.S.N.H. Bainbridge, Md. Date signed: 3/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02564

★ Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: ELKTON Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 Mos.

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 1 Mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: ELKTON

(If outside city or town limits, write RURAL and give nearest town)

Street No. 228 E. Main St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Josephine F Marcus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

8.(b) Name of husband or wife: Hyland P. Marcus

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 16 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	9	23		

9. Birthplace: Del City Del (Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER — 12. Name: Elisha Forsyth

13. Birthplace: Del.

MOTHER — 14. Maiden name: Martha Hudson

15. Birthplace: Del.

16. Informant: Mrs. Edith M. Woolever

Address: ELKTON Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 10-46 (month) (day) (year)

Cemetery or crematory: ELKTON Cemetery

Location: ELKTON Md.

18. Funeral director: H.W. Pippin & Son

Address: ELKTON Md

19. Mar 9 19 46 (Date rec'd by registrar) M Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 19 46 at 8P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 46 to March 7 19 46 and that I last saw her alive on March 7 19 46

Immediate cause of death	DURATION
Chronic Interstitial Nephritis	
Due to	
Due to	
Other conditions: Chronic Endocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert Baker M.D. M. D. or other

Address: Elkton Md Date signed: 3/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

02565

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: VETERANS ADMINISTRATION, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 14 yrs. 2 mo. 13 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Preston

City or town: Rowlesburg, W. Va.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: —
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: Messenger, Artie E.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Stella Messenger

6.(c) If alive, give age: Unknown

7. Birth date of deceased (mo., day, yr.): September 7, 1887

8. AGE: Years	Months	Days	If less than one day
58	6	12	— hrs. — min.

9. Birthplace: Radnor, W. Va.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3-20-46 (month) (day) (year)

Cemetery or crematory: Terra Alta Cemetery

Location: Terra Alta, W. Va.

18. Funeral director: Pennington & Son

Address: Pennington & Son, Havre de Grace, Md.

19. March 21 1946 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1946 at 7:05A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1932, to March 19 1946 and that I last saw him alive on March 19 1946

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic far advanced	Unknown
Due to:	
Due to:	
Other conditions ~~Paralysis~~ Syphilis of the Central Nervous System, Meningo-Encephalitic Type (Include pregnancy within 3 months of death)	Over 14 years

Major findings of operations: —

Date of op.: —

Autopsy results: — Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Trollinger

A.E. TROLLINGER, M.D., Clinical Director

Address: Veterans Administration, Perry Point, Md. Date signed: March 20, 46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

02566

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: Veterans Administration Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 7 mo. 23 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 319 N. Stricker Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: NASH, Samuel

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Minnie Williams
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 2-20-1890

8. AGE: Years	Months	Days	If less than one day
56	—	16	... hrs. ... min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: —

FATHER
12. Name: Isaac Nash
13. Birthplace: Raleigh, N.C.

MOTHER
14. Maiden name: Emma Dawls
15. Birthplace: North Carolina.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3-8-1946 (month) (day) (year)
Cemetery or crematory: Round Tree Cemetery,
Location: Wilson, N.C.

18. Funeral director: William A. Jackson
Address: 916 Pennsylvania Avenue
Baltimore, Md.

19. March 8 19 46 (Date rec'd by registrar) Irma E. Douglas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1946, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 43, to March 8 1946 and that I last saw him alive on March 8 1946

Immediate cause of death	DURATION
Cerebrah Hemorrhage	44 Hrs.
Due to: Arteriosclerosis, generalized	Over 2 yrs.
Due to:	
Other conditions: Psychosis with organic brain disease	Over 2 years

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Samuel C. Karlan, M.D.
SAMUEL C. KARLAN, Assistant Clinical Director
Address: Veterans Administration, Perry Point, Md. Date signed: 3-8-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02567

CERTIFICATE OF DEATH

Reg. Diat. No. 95

1. PLACE OF DEATH

County: Cecil

City or town: Rising Sun md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hanes Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Edna May Orr

3. (b) Social Security Number: 213-09-8080

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 11, 1900

8. AGE:

Years	Months	Days	If less than one day
46	1	16	hrs. min.

9. Birthplace: Port Deposit, Cecil Co. Md (Town, county, and state)

10. Usual occupation: Telephone Operator

11. Industry or business: Telephone

FATHER

12. Name: Charles Franklin Orr

13. Birthplace: Port Deposit, Md.

MOTHER

14. Maiden name: Ella Orr Cutler

15. Birthplace: Port Deposit, Md.

16. Informant: Ella Orr

Address: Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-9-1946 (month) (day) (year)

Cemetery or crematory: Hopewell Cemetery

Location: Port Deposit, Md.

18. Funeral director: Ralph M Reed

Address: Rising Sun, Md.

19. Mch 8- 1946 L M Worthington Registrar

(Date rec'd by registrar)

Permit issued 3-8-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1946 at 5P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 1946 to 3-6 1946

and that I last saw h... alive on 3-6 1946

Immediate cause of death	DURATION
(a) Coronary Embolism	
Due to: (b) Chronic Myocarditis	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R E Dodson MD M. D. or other

Address: Rising Sun Md Date signed: 3-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02568

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: VETERANS ADMINISTRATION, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 13 days
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Maryland
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: OHIO County: Columbiana
City or town: East Liverpool, Ohio
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, gives LOCATION)
2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: ROACH, William R.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Hazel Roach (nee Allen) 6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 3-14-1894

8. AGE: Years	Months	Days	If less than one day
52		3	— hrs. — min.

9. Birthplace: Freeman Sta., Ohio (town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: —

FATHER
12. Name: Robert Van Deen Roach
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mamie Price
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3-19-1946 (month) (day) (year)

Cemetery or crematory: Spring Grove
Location: E. Liverpool, O.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. 3/19/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 19 46, at 12:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 19 46 to March 17 19 46 and that I last saw him alive on March 17 19 46

Immediate cause of death	DURATION
Syphilis of the Central Nervous System, tabetic type	Over 3 years
Due to:	
Due to:	
Other conditions: Psychosis with syphilis of the Central Nervous System Over 3 yrs. tabetic type. (Include pregnancy within 3 months of death)	

Major findings of operations: —
Date of op. —
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: A. E. TROLLINGER, M.D., Clinical Director
Address: Veterans Administration, Perry Point, Md. Date signed 3-18-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02569

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Philadelphia

City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3820 Chestnut Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW 1

3.(a) FULL NAME: RODGERS, John Foster

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Vanada K. Rodgers

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): June 2, 1879

8. AGE: Years	Months	Days	If less than one day
66	9	11	— hrs. — min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-14-46 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery
Mifflintown, Pa.

Location:

18. Funeral director: Pennington & Son

Address: Pennington & Son, Havre de Grave Maryland

19 Mar 14 19 46 Irma E. Dunphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 19 46 at 8:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 19 46, to March 13 19 46 and that I last saw him alive on March 13 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Cerebral arteriosclerosis	Over 1 yr.
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, M.D. Clinical Director
(Medical examiner)

Address: Veterans Administration, Perry Point, Md. Date signed 3-14-46

VS A15 6-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02570

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Denton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: —
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: TAYLOR, George T.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Unmarried

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 4-9-1911

8. AGE: Years	Months	Days	If less than one day
34	11	13	— hrs. — min.

9. Birthplace: Breston, Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Unknown
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3-22-46 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Denton, Maryland

18. Funeral director: Virgil Moore

Address: Denton, Md.

19. Mar 22 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 46 at 2:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1946, to March 22 1946 and that I last saw him alive on March 22 1946

Immediate cause of death	DURATION
Nephritis, acute	2 weeks
Due to with Uremia	1 week
Pulmonary edema	
Due to Myocardial failure	3 days
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Rollinger

A. E. ROLLINGER, M.D., Clinical Director

Address: Veterans Administration, Perry Point, Md. Date signed: 3-22-46

Evidence for change of age of deceased is shown on

02571

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

FILM No. I 01 MAR 13 1946

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Clara B. Touchstone

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 28, 1859

8. AGE: Years	Months	Days	If less than one day
~~85~~ 86	4	2	hrs. min.

9. Birthplace: Port Deposit, Cecil, Md. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business: Jacob Tome Institute

FATHER 12. Name: James Touchstone

13. Birthplace: Md.

MOTHER 14. Maiden name: Virginia A. Owens

15. Birthplace: Perryville, Md.

16. Informant: Walter Touchstone

Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1946 (month) (day) (year)

Cemetery or crematory: Hopewell Cemetery

Location: Port Deposit, Md. Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Mar 5 1946 (Date rec'd by registrar) Irene E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2-46 at 2.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20 1946 to March 2 1946.

and that I last saw her alive on March - 2 1946.

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs.
Due to: Chronic Endocarditis	10 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. J. Benson, M. D. M. D. or other

Address: Port Depart, Md. Date signed 3/4/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md.)

CERTIFICATE OF DEATH

02572

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Colora
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war:

3.(a) FULL NAME Esther Watson

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Pleasure Watson
6.(c) If alive, give age: Alive years

7. Birth date of deceased (mo., day, yr.): Feb. 9 1913

8. AGE: Years	Months	Days	If less than one day
33	1	17	hrs. min.

9. Birthplace: Allegheny Co, M.C. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: at Home

FATHER
12. Name: Looney Anderson
13. Birthplace: Allegheny Co, M.C.

MOTHER
14. Maiden name: Vehnie Brannerger
15. Birthplace: Allegheny Co, M.C.

16. Informant: Pleasure Watson
Address: Colora, Cecil Co, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 17 1946 (month) (day) (year)
Cemetery or crematory: Union Cem.
Location: Allegheny Co, M.C.

18. Funeral director: H.S. Bailey
Address: Darlington Md.

19. Mch 17 1946 (Date rec'd by registrar) H. L. Washington Registrar

Permit issued Mch 17-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1946 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Compound fracture of Skull &	
Due to Crushed left side of Chest.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 3/16-46
Where did injury occur? Battle Summit (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Road.
Means of injury: Automobile Injured at work?

23. SIGNATURE: R. L. Woodson M.D. M. D. or other
Address: Rising Sun Md. Date signed: 3-16-46

Medical Examiner Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02573

Reg. Diat. No. 95

1. PLACE OF DEATH:

County Cecil

City or town Elkton, Md R.F.D #5

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Elkton Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Taylor Watson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Ada Watson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1868

8. AGE:	Years	Months	Days	If less than one day
	77	6	19	..... hrs. ..... min.

9. Birthplace Elkton, Md.

(Town, county, and state)

10. Usual occupation retired

11. Industry or business

FATHER 12. Name Thomas Watson

FATHER 13. Birthplace Baltimore County Md.

MOTHER 14. Maiden name Lydia Taylor

MOTHER 15. Birthplace Maryland.

16. Informant Martha R. Mackey

Address Elkton, Md R.F.D #5

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31. 1946 (month) (day) (year)

Cemetery or crematory Sharp's

Location Near Sewisville, Pa.

18. Funeral director J. E. Tyson

Address Rising Sun, Md.

19. March 30 19 46 (Date rec'd by registrar) Emmaline Cunningham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 46 at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 46 to March 29 19 46 and that I last saw h... alive on 3-27-46 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Contributory	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D.

M. D. or other

Address Rising Sun Md. Date signed 3/30 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

★ 025794 Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-1M

1. PLACE OF DEATH:

County: Cecil

City or town: North East
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Rufus K. Wells

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emily Simpns Wells

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): August 3 1887

8. AGE:

Years	Months	Days	If less than one day
58	7	24	...hrs. ...min.

9. Birthplace: Havre de Grace Harford Co Md
(Town, county, and state)

10. Usual occupation: Merchant (Retired)

11. Industry or business: General

FATHER 12. Name: Ira Wells

FATHER 13. Birthplace: Havre de Grace, Md

MOTHER 14. Maiden name: Annie E Mnfwiler

MOTHER 15. Birthplace: Wrightsville Pa

16. Informant: Mrs Emily S Wells

Address: North East, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 30 46 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R. Frank

Address: North East, Md.

19. 3/30/46 (Date rec'd by registrar) Lida V. Arena Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1946 at 1.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 to Mar 27- 46 and that I last saw him alive on Mar 27-46

Immediate cause of death	DURATION
Coronary Thrombosis	30 mins
Due to: Hypertension and hypertrophy of Heart	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: D A Emmitt M. D. or other

Address: North East, Md Date signed: Mar 27-46

02575

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Edward P. Whitaker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Hasson Whitaker

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): July 29, 1862

8. AGE: Years	Months	Days	If less than one day
83	7	18	...hrs. ...min.

9. Birthplace: Port Deposit, Cecil, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Samuel Whitaker

13. Birthplace: Cecil Co., Md.

MOTHER — 14. Maiden name: Margaret Whitelock

15. Birthplace: Harford Co., Md.

18. Informant: Mary Whitaker

Address: Port Deposit, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20, 1946 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Port Deposit, Md. Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. (Date rec'd by registrar) March 19 1946 Irma E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March - 18 1946 at 4:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 45 1945 to March 16 1946 and that I last saw h... alive on March 16 - 1946

Immediate cause of death	DURATION
Chronic Myocarditis	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: C. F. Bruson, M.D. M. D. or other

Address: Port Deposit, Md. Date signed: 3/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

02576

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 3 mos. 1 day
Hospital, institution, or street address where death occurred:
Vets. Adminstration Hosp.,
How long in hospital or institution? 1 yr. 3 mos. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Cec~~
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 732 E. Biddle St.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish-American ✓

3. (a) FULL NAME: WHITE, Clinton Amos

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White W	Married

6.(b) Name of husband or wife: Mrs. Emma B. White
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): September 29, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	5	6	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: Unknown
FATHER 12. Name: Robert H. White
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Laura V. Murry
15. Birthplace: Baltimore, Md.
16. Informant: Records, Vets. Administration Hosp.
Address: Perry Point, Md.
17. Removal Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1946 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Frederick Road, Baltimore, Md.
18. Funeral director: W.M. A. COOK, INC.
Address: St. Paul & Preston Sts., Balto., Md.
19. Mar 6 - 19 46 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1946 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 1944 to March 5 1946 and that I last saw him alive on March 5 1946

Immediate cause of death	DURATION
Hemorrhage, Cerebral	15 hrs.
Due to: Arteriosclerosis, cerebral, with Thrombosis	over 6yrs.
Due to: Aneurysm, aorta	" 2 "
Diabetes, Mellitus	" 2 "
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt. Col., MC, M.C., Dir.
Address: VAH, Perry Point, Md. Date signed 3-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02577

CERTIFICATE OF DEATH

Reg. Diat. No. 97

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George W. Yocum

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 28 1875

8. AGE: Years 70 | Months 9 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Childs Cecil Co Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Joseph T. Yocum

FATHER 13. Birthplace Md

MOTHER 14. Maiden name Catherine Spence

MOTHER 15. Birthplace Md

16. Informant Frank Yocum

Address Elkton R No 5 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-27-46 (month) (day) (year)

Cemetery or crematory Cherry Hill

Location Cherry Hill, Maryland

18. Funeral director Joseph R. Gidus

Address North East Md

19. Mar 26 1946 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 7.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cremated charred body.	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3/26-46

Where did injury occur? Marley Mill Cecil Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fire Injured at work?

23. SIGNATURE R. E. Dodson M.D. Medical Examiner for Cecil County

M. D. or other

Address Rising Sun Md Date signed 3/26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15